Advanced Orthopedic
& Sports Medicine Specialists

PATIENT NAME (PRINT): ____

DATE OF BIRTH: ____

I acknowledge receipt of a copy of the Privacy Practices for Protected Health Information for Advanced Orthopedic & Sports Medicine Specialists, P.C. and understand that if I have any questions or concerns regarding the content of this matter; I will speak with the appropriate person as so stated in the agreement.

____ ________________________

SIGNATURE DATE

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